STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001358	A. BUILDING: _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLESTON REHAB & HEALTH CARE CENT	716 EIGHTEENTH STREET CHARLESTON, IL 61920

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210c) 300.1210d)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Requirements are not met as evidenced by: Based on record review and interview, the facility	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 failed to supervise a resident (R18) while on a bedside commode. This failure resulted in R18 falling and sustaining a Right Hip Fracture. R18 is one of four residents reviewed for falls in the sample of 15. Findings include: R18's Physician Order Sheet (POS) dated October 2015 documents the following diagnoses: Lewy Body Dementia, Macular Degeneration, History of Spinal Infarct with Abdominal Aortic Aneurysm Repair and History of Right Hip Fracture. The Minimum Data Set (MDS) dated 12/13/14 documents R18 as moderately cognitively impaired and requires extensive assist with staff providing weight bearing support during toileting and transfers. The same MDS documents that R18 is not steady without staff assistance. A facility Fall Risk Assessment dated 12/13/15 documents R18 as high risk for falls with a history of multiple falls. R18's Plan of Care dated December 2014 documents that R18 has risk factors for falls that require monitoring related to, mental status and weakness as evidenced by a decline in activities of daily living. A facility report titled "Fall Log" dated February 2015 documents R18 with falls on 2/4/15 and 2/26/15. A Facility Incident Report sent to the State Agency dated 2/26/15 documents the following on R18: "On February 26, 2015 at approximately 1:35 am, (Certified Nursing Assistant), (E10) heard a noise coming from (R18's) room. (R18) was observed on the floor, in a right side-lying position. The (Licensed Practical Nurse/Charge Nurse), E3 was	S9999		

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notified and assessed (R18) immediately." The report documents that R18 was sent to the hospital and admitted with a Right Femoral Neck Fracture (Hip Fracture). Nursing Notes for this 2/26/15 incident/fall document that R18's fall was unwitnessed and was last seen sitting on the commode. R18 complained of right hip and leg pain and was sent to the hospital and was admitted. Nursing Notes on 3/2/15 document R18 returning to the facility Status Post Open Reduction with Internal Fixtion (surgical repair of the right hip).

On 10/22/15 at 1:30 pm E1, Administrator confirmed that R18 was left unsupervised on the toilet and stated "(R18) should not have been left unattended on the toilet."

On 10/22/15 at 4:40 pm Z2, Primary Care Physician for R18 stated that R18 should never have been left on the commode by herself. Z2 stated that R18 had not walked in several years due to a Spinal Infarct and R18's dementia has steadily gotten worse. Z1 stated "(R18) has been totally dependent upon staff in all her personal care...it's upsetting that they left (R18) unattended, causing a hip fracture."

On 10/23/15 at 8:55 am E3 Licensed Practical Nurse acknowledged that E3 was the Charge Nurse on duty the night of 2/26/15. E3 stated that R18 was left unattended on a bedside commode, not the toilet. E3 stated "I am not sure why (R18) had a bedside commode, but (R18) was a full assist and there is no excuse for (R18) being left alone on the bedside commode."

On 10/23/15 at 10:55 am E10 acknowledged that E10 was the Certified Nursing Assistant (CNA) that left R18 on the bedside commode

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S9999	Continued From page 3 unattended. E10 stated "It was dumb, I know better. I was the only CNA on the hall at the time and I thought I heard another resident yelling for help and I left (R18) alone. I should never have done that. I knew (R18) was not to be left alone and (R18) had fallen before. I feel really bad (R18) fell and got a broken hip." (A) 300.610a) 300.1010h) 300.1210a) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident,	S9999		

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S9999	Continued From page 4 injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Requirements are not met as evidenced by: Based on record review, observation and interview, the facility failed to follow their Intravenous (IV) Policy and Infection Control Policy by not providing nursing services for IV maintenance, monitoring, dressing changes, IV flushes, hand hygiene, and Physician notification. These failures resulted in a 27 hour and 59 minute delay in treatment of a blood clot and potential for infection, in an immune-compromised resident (R21) on the supplemental sample.	S9999		

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S9999	Continued From page 5 Findings include: R21's Physician Order Sheet (POS) dated 10/19/15 - 10/31/15, (upon return to the facility from the local hospital) documents the following diagnoses: Sepsis, Small Bowel Obstruction / Abscess, Left Hip Fracture (8/15/15) with Hip Replacement, and Anemia. This Physician Order Sheet also documents the following medications: Ceftriaxone (antibiotic), two grams/100 ml (milligram) / injectable, give two grams per IV (in the vein), PICC (Peripheral Inserted Central Catheter) line, run over thirty minutes at a rate of 200 ml per hour, daily, times six weeks and a Sodium Chloride Flush to the PICC line per protocol (5 cc (cubic centimeters) before and after medication administration). The facility policy "Infusion Maintenance Table" dated 2007, documents the following: "PICC, five ml, normal saline (Sodium Chloride) flush, infuse medication then five ml normal saline....Transparent Dressing Changes, 24 hours post insertion, on admission then every week and as needed. Measure upper arm circumference and external catheter length... Monitor IV site every shift" R21's Assessment Discharge, from the local hospital, dated 10/19/15 at 10:50 am, documents the following: "scattered bruising at the right hip surgical incision and redness on the buttock and perineal area." There is no indication on the body map, of redness to the left upper arm, PICC site. R21's Nurses Note, dated 10/19/15 at 4:10 pm, documents the following: "Resident returned to the facility alert and oriented... see Nursing Assessment."	S9999		

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S9999	Continued From page 6 R21's Nursing Admission Assessment dated 10/19/15, without a time, documents on the body map, the following: "Left upper arm PICC, red, possible PICC infiltration." There is no documentation that the Physician was notified per nursing standard of practice and R21's Care Plan. R21's Treatment Administration Record (TAR), dated 10/19/15 - 10/31/15, documents the following: "Change PICC line dressing weekly." The same TAR documents no nurse signature / initials on the PICC line dressing treatment order. There is no entry on the TAR to monitor the insertion site or measure the AC (arm circumference) and ECL (external catheter length), of the upper arm, for adverse signs and symptoms every shift, as the IV protocol and Care Plan document. R21's Care Plan, dated 10/19/15, documents the following: "Maintain IV for the duration of treatment. Monitor site every shift for infection (pain, drainage, redness and swelling). Monitor every shift and as needed for infiltration (redness, swelling, pain, boggy appearance). Report signs or symptoms of infiltration or infection to the doctor for treatment and follow up recommendations." On 10/20/15 at 11:50 am, E5, Registered Nurse (RN), entered the medication room after taking the keys out of her pocket. Without washing her hands or using hand sanitizer, E5 set up supplies for R21's IV flush and medication administration on top of a visibly soiled (dry,white milky substance and white crumbs) treatment cart. Without washing her hands or using hand sanitizer, E5 prepared the bottle of Rocephin (name brand for Ceftriaxone) and IV tubing, then	S9999		

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placed a pair of latex gloves in her pocket. Without washing her hands or using hand sanitizer, E5, exited the medication room with the IV medication and supplies. E5 went down the hallway, entered R21's room, partially closed R21's the door (there was no privacy curtain in R21's room), laid two alcohol prep pads and two 10 ml syringes (one out of the sterile package and one still in the sterile package) which contained Sodium Chloride, on a newspaper. With contaminated hands, E5 set up the IV pump and primed the IV tubing. Without washing her hands or using hand sanitizer, E5 assisted R21 with the removal of R21's long sleeve shirt. E5, touched R21's hair and shoulder while E5 assisted an unknown Certified Nursing Assistant (CNA) with draping R21's left shoulder and left breast with a hospital gown. R21's hospital gown remained untied. With contaminated hands, E5, put on the latex gloves from her pocket and attempted to set the dose and rate on the IV pump, three times. With the same contaminated gloves, E5, touched R21's, left upper arm PICC site as R21 flinched. R21's PICC line transparent dressing was not labeled with the date, time or the nurses initials to show the last time it was changed. R21's inner, upper left arm was red and swollen, approximately five inches long by three inches wide. E5 stated "I think that redness and swelling is from a previous IV." E1, Administrator/RN entered the room and reiterated "that is from an IV that infiltrated at the hospital." At 12:12pm, E5, wearing the same contaminated gloves, picked up an alcohol pad and a syringe from off the newspaper, removed the heplock (IV tubing connection site) cap, wiped the heplock with the alcohol pad, flushed the PICC line with 10 ml's of Sodium Chloride (the facility IV protocol, documents that 5 ml's are to be used before and after the administration of

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medication), attached the medication tubing and started the IV medication pump infusion. (nurse standard of practice is to notify the physician before administering medication through an IV that presents with signs and symptoms of infection or infiltration). E5, removed the gloves, washed her hands and donned new gloves. With the clean gloves, E5 adjusted the contaminated IV pump to set the dose and rate to deliver the medication. With the same contaminated gloves, E5 removed a tight bandage from R21 left wrist. R21's wrist and bandage were soiled with a moderate amount of dried blood. With the same soiled gloves, E5 picks up the second syringe from on top of the newspaper and puts the syringe in her pocket. The soiled bandage remained in E5's opposite hand as she exited R21's room. E5 carried the bloody bandage to the medication cart trash before removal of the soiled gloves and hand hygiene. At 12:45pm, E5 entered R21's room to turn off the beeping IV pump. E5, did not wash her hands or use hand sanitizer before E5 reached into her pocket and pulled out a pair of latex gloves and the syringe of normal saline. E5 flushed R21's IV with 10 ml of normal saline.

R21's Medication Administration Record (MAR) dated 10/20/15, scheduled at 12:00 pm, documents R21's first dose of IV medication was administered by E5 as follows: Ceftriaxone, two grams/100 ml / injectable, give two grams per IV PICC line, run over thirty minutes at a rate of 200 ml per hour, daily, times six weeks and a Sodium Chloride Flush to the PICC line per protocol, (5 ml before and after medication administration). There was no documentation of the PICC line location on the MAR.

R21's Nurses Note dated 10/20/15 at 3:50 am,

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S9999	Continued From page 9 documents the following: "Alert and confused, would yell freq (frequently), up until mid shift. Was pleasant but anxious. No complaint of pain." The same Nurses Note does not document an assessment of the PICC site nor that the Physician was notified for a change in cognition or mention R21's left upper arm PICC site. On 10/20/15 at 1:45 pm (27 hours and 59 minutes after the first signs of PICC complications were identified on the admission assessment), E5, RN documents in R21's Nurses Note, the following: "... (R21's) Left upper extremity with ecchymosis (a discoloration of the skin resulting from bleeding underneath, typically caused by bruising), fading with edema (swelling) related to previous PICC line displacement...". The same Nurses Note has no mention of Physician notification." On 10/20/15 at 2:30 pm, E5, Registered Nurse (RN) documents in R21's Nurses Note, the following: "See SBAR (Situation Background Assessment Recommendation) for details related to an unwitnessed fall." The facility's SBAR dated 10/20/15 is not timed and documents the following: "Unwitnessed fall related to confusion. Resident (R21) sent to ER (emergency room) by ambulance as ordered by Doctor (Z5, Primary Care Physician)." There is no documentation related to left arm PICC site swelling and redness. The Hospital's Emergency Room Report dated 10/20/15 at 2:49 pm, documents the following: "(R21) is found to have swelling and redness to the medial aspect of (R21) left upper extremity (arm) distal to her PICC line extending down the arm across the medial aspect of the elbow and to the proximal (nearest) aspect of her forearm.	S9999		

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There is some slight increased warmth in this area... Left upper extremity venous Doppler ultrasound was done, reviewed and did show evidence of DVT (deep vein thrombosis) ...Impression Left upper extremity DVT, suspected catheter induced. "

The Hospital's Ultrasound Report dated 10/20/15, untimed, documents the following: (R21) "Left upper extremity...There is a partial thrombosis of the axillary (armpit) vein to the subclavian (under the collar bone) vein.

On 10/22/15 at 10:00 am, Z3, Medical Director stated "the nursing home should follow the standards of practice. The nurses should have monitored (R21's) left arm every shift, as needed and before infusing any medication. I expect the nursing home to look for any signs of infiltration or infection and report any abnormal findings to me. They should follow their protocol. I was not notified of any abnormal signs or symptoms, absolutely not. I would have immediately ordered an ultrasound to rule out any complications with the (R21) PICC. I should have been notified earlier."

On 10/23/15 at 10:45 am, Z5, Primary Care Physician (PCP) for R21, stated "A nurse called and reported a fall and did not mention anything about (R21's) arm swelling. I sent (R21) to the ER to evaluate the fall. I am very upset about this. I should have been notified immediately of the PICC site changes."

On 10/23/15 at 4:15 pm, E2, Director of Nursing (admitted R21 on 10/19/15) stated "I thought the redness and swelling was from a PICC line that infiltrated in the hospital. I did not notify her (R21) doctor (Z5) because her arm was only red and

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swollen a little bit, about three or four inches. I didn't actually measure it. I didn't change the dressing and did not question when the dressing on her PICC was last changed. No it (PICC dressing) was not dated or signed but it should have been. I needed to question it or change it (PICC dressing) myself when I admitted (R21)."

The facility policy "Infection Control, Surveillance and Monitoring" dated 5/07 documents the following: "IV site purulent drainage or cellulitis from the site of any invasive venous or arterial line, with or without positive culture results....Cellulitis confirmed by clinical judgement, i.e. with heat, swelling, erythema (redness), and or tenderness." The same policy documents the following: "All staff will wash their hands, promptly and as thoroughly as possible after each resident contact. Wash hands after contact with blood, body fluids, secretions, excretions, and equipment or articles contaminated by them. Hand washing is an important component of the infection control precautions".

(B)

300.2010a)1

Section 300.2010 Director of Food Services
a) A full-time person, qualified by training and experience, shall be responsible for the total food and nutrition services of the facility. This person shall be on duty a minimum of 40 hours each week.

1) This person shall be either a dietitian or a dietetic service supervisor

300.330 Definitions -

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S9999	Continued From page 12 Dietetic Service Supervisor - a person who: is a dietitian; or is a graduate of a dietetic technician or dietetic assistant training program, corresponding or classroom, approved by the American Dietetic Association; or is a graduate, prior to July 1, 1990, of a Department-approved course that provided 90 or more hours of classroom instruction in food service supervision and has had experience as a supervisor in a health care institution which included consultation from a dietitian; or has successfully completed a Dietary Manager's Association approved dietary managers course; or is certified as a dietary manager by the Dietary Manager's Association; or has training and experience in food service supervision and management in a military service equivalent in content to the programs in the second, third or fourth paragraph of this definition. This requirement is not met as evidenced by the following: Based on interview and record review the facility failed to have a qualified Dietetic Services Supervisor who works 40 hours per week in the facility. This has the potential to affect all 58 residents. Findings include: On 10-21-15 at 5:35pm E12, Dietary Manager stated "I started in the position as Dietary Manager on September 16, 2015. (E19, Consultant Dietitian) told me they would not put me in the Dietary Managers Correspondence Course until after the first of the year." E12 verified that she does not yet meet the training and experience requirements to qualify as a Dietetic Service Supervisor.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001358	A. BUILDING: _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 13 According to records provided by E1, Administrator E18, the facility's prior qualified Dietary Manager's last day of employment was 7-15-15. The Resident Census and Conditions of Residents Report on 10-20-15 reflects a census of 58 residents. (AW) 300.1230d) Section 300.1230 Direct Care Staffing d) Each facility shall provide minimum direct care staff by: 1) Determining the amount of direct care staffing needed to meet the needs of its residents; and 2) Meeting the minimum direct care staffing ratios set forth in this Section. k) Effective September 12, 2012, a minimum of 25% of nursing and personal care time shall be provided by licensed nurses, with at least 10% of nursing and personal care time provided by registered nurses. Registered nurses and licensed practical nurses employed by a facility in excess of these requirements may be used to satisfy the remaining 75% of the nursing and personal care time requirements. (Section 3-202.05(e) of the Act) These requirements were not met as evidenced by: Based on record review and interview the facility failed to meet staffing requirements for additional direct care staff hours for two of the 14 consecutive days reviewed. This failure has the potential to affect all 58 residents in the facility. Findings include: The staffing spread sheet dated 10/1/15 through 10/14/15 documents the daily census for skilled and intermediate care residents and the staffing	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 14 hours for Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Certified Nursing Assistants (CNAs), Social Service, Therapy, and Director of Nursing hours. The spread sheet dated 10/1/15 through 10/14/15 documents a minimum of 162.5 Direct Care staffing hours per 24 hours. The staffing spreadsheet for 10/4/15 through 10/14/15 documents two days 10/4/15 and 10/10/15 that did not meet the 162.5 hours of minimum Direct Care staff per 24 hours. The Direct Care staffing hours for 10/4/15 and 10/10/15 are as follows: On 10/4/15, 150.60 hours (includes 4.0 Director of Nursing hours and 2.60 Therapy hours) is documented, resulting in a shortage of 11.9 hours for Certified Nursing Assistants. On 10/10/15 - 148.00 hours (includes 4.0 Director of Nursing hours and 4.00 Therapy hours) is documented, resulting in a shortage of 14.5 hours for Certified Nursing Assistants. On 10/9/15 at 3:20 pm E2, Director of Nursing, confirmed the daily census and staffing documented on the staffing sheet for the time period of 10/1/15 through 10/14/15 were accurate. E2 stated " I can see that there were not enough CNA's on. We just don't have enough people sometimes." The Resident Census and Conditions of Residents Report dated 10/20/15 documents there are 58 residents residing at the facility. (AW)	S9999		

Imposed Plan of Correction
NAME OF FACILITY: Charleston Rehab & Health Care Center
DATE AND TYPE OF SURVEY: October 23, 2015, 2015
Annual

300.1210a)
300.1210b)
300.1210d)6)
300.3240a)

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

Attachment B
Imposed Plan of Correction

This will be accomplished by:

I. Provide education for all departments on facility's policy and procedures for Fall Prevention Program of incidents/accidents with emphasis on supervision of residents that require assistance for transfers for toileting.

II. Director of Nursing or Designee will monitor nurse's aides to ensure residents who require assistance for toileting are not left alone unless care plan indicates otherwise.

III. Nursing administration will do random observations of residents that are toileted to ensure direct care staff is providing supervision as per residents care plan.

IV. Quality Assurance programs implemented to ensure continued compliance with the facilities policies and procedures.

V. Facility Administrator to provide oversight for continued compliance.

Date of completion: Ten days from receipt of the Imposed Plan of Correction

12/11/2015/JP